SERFF Tracking Number:	*AMFA-125612889*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38807*
Company Tracking Number:	*15524A 6358 3/08*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Employers Request for Group Insurance*		
Project Name/Number:	*15524A 6358 3/08/15524A 6358 3/08*		

Filing at a Glance

Company: Ameritas Life Insurance Corp.

Product Name: Employer's Request for Group Insurance	SERFF Tr Num: AMFA-125612889	State: ArkansasLH
TOI: H10G Group Health - Dental	SERFF Status: Closed	State Tr Num: 38807
Sub-TOI: H10G.000 Health - Dental	Co Tr Num: 15524A 6358 3/08	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Janis Landon	Disposition Date: 04/30/2008
	Date Submitted: 04/28/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 15524A 6358 3/08	Status of Filing in Domicile: Pending
Project Number: 15524A 6358 3/08	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Trust
Filing Status Changed: 04/30/2008	
State Status Changed: 04/30/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

RE: Ameritas Life Insurance Corp.

NAIC No.: 0943-61301

FEIN No.: 47-0098400

Form No.: 15524A 6358 3/08 (Employer's Request for Group Insurance)

Dear Sir/Madam:

SERFF Tracking Number:	*AMFA-125612889*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38807*
Company Tracking Number:	*15524A 6358 3/08*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
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Project Name/Number:	*15524A 6358 3/08/15524A 6358 3/08*		

Enclosed for your review and approval is the above referenced form. The anticipated effective date is May 15, 2008 or upon approval. This is a new form and will not replace any other form.

This form will be used for those employers subscribed to and elect coverage under a group trust policy which provides dental, orthodontia and vision coverages under the “Bright One” plan. The group trust is issued to the trustees of the Banker’s Life Nebraska Preferred Trust, which is sitused in the state of Nebraska. The trust was formed for the purpose of implementing group insurance plans for the benefit of employees of employers in various industries as defined by the trust agreement.

These forms scored a 50 on the Flesch readability scale. No part of this filing contains any unusual or possibly controversial items from normal company or industry standards.

If you should have any questions, please don’t hesitate to contact me at 800-745-1112, ext. 87997, fax 402-467-7956 or email jlandon@ameritas.com.

Sincerely,
Janis Landon, FLMI, ACS
Contract Analyst

Company and Contact

Filing Contact Information

Janis Landon, Contract Analyst	jlandon@ameritas.com	
5900 O Street	(800) 745-1112 [Phone]	
Lincoln, NE 68501-1889	(402) 467-7956[FAX]	

Filing Company Information

Ameritas Life Insurance Corp.	CoCode: 61301	State of Domicile: Nebraska
5900 O Street	Group Code: 943	Company Type:
P O Box 81889		
Lincoln, NE 68501-1889	Group Name:	State ID Number:
(800) 756-1112 ext. [Phone]	FEIN Number: 47-0098400	

SERFF Tracking Number:	*AMFA-125612889*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38807*
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TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
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Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ameritas Life Insurance Corp.	$20.00	04/28/2008	19938942

SERFF Tracking Number:	*AMFA-125612889*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38807*
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Product Name:	*Employers Request for Group Insurance*		
Project Name/Number:	*15524A 6358 3/08/15524A 6358 3/08*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/30/2008	04/30/2008

SERFF Tracking Number:	*AMFA-125612889*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38807*
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Project Name/Number:	*15524A 6358 3/08/15524A 6358 3/08*		

Disposition

Disposition Date: 04/30/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFA-125612889*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38807*
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TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Employers Request for Group Insurance*		
Project Name/Number:	*15524A 6358 3/08/15524A 6358 3/08*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Employer's Request for Group Insurance	Approved-Closed	Yes

SERFF Tracking Number:	*AMFA-125612889*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*38807*
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TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Employers Request for Group Insurance*		
Project Name/Number:	*15524A 6358 3/08/15524A 6358 3/08*		

Form Schedule

Lead Form Number: 15524A 6358 3/08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	15524A 6358 3/08	Application/ Enrollment Form	Employer's Request for Group Insurance	Initial		50	6358 BrightOp Emp Subscription. A_8.pdf

BrightOptions® Plans

Employer's Request & Subscription to the Trust

Marketed and Administered by: HealthPlan Services

Insured by: AMERITAS LIFE INSURANCE CORP.

SUBSCRIPTION AGREEMENT

The undersigned employer hereby applies for membership in the Bankers Life Nebraska Preferred Trust ("Trust") and subscribes to, adopts, and agrees to be bound by all the terms and conditions of the declaration of the Trust. It is understood that the Trust must accept the application in writing before membership is approved.

Applicant's Signature X_____ ***Title***_____ ***Date*** _____

REQUEST FOR GROUP INSURANCE

Having applied for membership in the Trust, the Applicant elects to participate in the dental program offered under the Trust and underwritten by Ameritas Life Insurance Corp. ("Ameritas" and/or "Company"). The Applicant agrees to meet the terms and conditions of the group insurance policy issued to the trustees of the Trust.

1. Employer's legal business name _____
2. Employer is registered as ❑ Corporation ❑ Partnership ❑ Proprietorship ❑ Other _____
3. Street address _____
   Street City State ZIP Code
4. Mailing address (if different) _____
   Street City State ZIP Code
5. Attention _____ Title _____
6. Phone number ( ) _____ Fax number ( ) _____
7. Name and address of any subsidiaries _____
8. Nature of Business or Industry _____ SIC code (if known) _____
9. Tax ID number _____ Date issued _____ Email _____
10. Number of full-time employees _____
11. Requesting Plan

[	❑ Traditional	❑ Progressive	❑ Saver	❑ Access	]
	❑ $750 annual max.	❑ $750 annual max.	❑ $750 annual max.	❑ $1,000 annual max.	
	❑ $1,000 annual max.	❑ $1,000 annual max.	❑ $1,000 annual max.	❑ $1,500 annual max.	

12. Requested effective date (must be first of the month) Month _____ Year _____
13. Request billing option ❑ Monthly
14. Prior coverage administered by HealthPlan Services? ❑ Yes ❑ No If yes, Account No._____
15. Mail administrative kit and policy/certificates to ❑ Employer ❑ Agent

AGREEMENTS

The Applicant understands that he/she, and not HealthPlan Services, Ameritas, nor the Trustees, is the Plan Administrator and Fiduciary as defined in the Employee Retirement Income Security Act of 1974, as amended.

The Applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief.

If this application is accepted by Ameritas, group insurance at the current Company's rates and under the terms applied for shall take effect as of the date shown in number 12 above. If this application is not accepted, any premium advanced shall be refunded. Ameritas reserves the right to reject any case which, in its opinion, does not conform to sound underwriting criteria. No insurance is in force until written acceptance is received.

STATEMENTS

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim (see state specific statements).

The policy provides dental and eye care benefits only. Review your policy carefully.

Signed at (City)_____(State)_____ on (Month)_____ (Day)____ (Year)_____

Printed Name and Title _____ Applicant's Signature X_____

Complete reverse side

Legal Business Name _____

Soliciting Agent/Broker Printed Name _____ Signature _____

For FL Agents/Brokers only, provide FL License number _____

Phone number (include area code) _____ Fax number (include area code) _____
(Important: may assist in case issue)

Email address _____

Service Fees Payable to

Name _____ Check one: ❑ Social Security # ❑ Tax ID # _____
(Important: may assist in case issue)

Address _____
City State ZIP Code

Phone number (include area code) _____ General Agent Fax number (include area code) _____

❑ Copy of my Ameritas Life Insurance Corp. license

❑ Not licensed with Ameritas

FOR GENERAL AGENT'S USE

Agent's/Broker's Statement

To the best of my knowledge and belief, all statements in the Employer's Request for Group Insurance and Group Insurance Enrollment Cards are complete and true. I represent the applicant for the Insurance, not the Insurance Company.

If I am not already appointed with Ameritas Life Insurance Corp., I understand and agree that before I present this product to any client, I must apply to and be appointed with Ameritas. The applicant has been advised not to terminate any existing coverage until receiving notice that the coverage being applied for is accepted. I agree that I have no right to bind this coverage, alter terms of the Insurance Contract or Employer's Request for Group Insurance, or adjust any claim for benefits under the insurance contract.

Agent's/Broker's Signature Date

Note for California Residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. For group policies issued, amended, delivered or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

Note for Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Note for Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Note for Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Note for New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Note for Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

A signed copy of this form received by electronic transmission will be deemed to be an original.

SERFF Tracking Number:	*AMFA-125612889*	*State:*	*Arkansas*
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Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFA-125612889*	*State:*	*Arkansas*
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TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Employers Request for Group Insurance*		
Project Name/Number:	*15524A 6358 3/08/15524A 6358 3/08*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice — Approved-Closed — 04/30/2008

Comments:

Attachments:

ar-readability-certification-alic.pdf

ar-regulation 19-certification-alic.pdf

Review Status:

Bypassed -Name: Application — Approved-Closed — 04/30/2008

Bypass Reason: see form schedule

Comments:

STATE OF ARKANSAS

CERTIFICATE OF READABILITY

INSURER: Ameritas Life Insurance Corp.

This is to certify that the attached form(s) has achieved a Flesch Reading Ease Score of:

FORM NO:	FLESCH SCORE:	FORM NAME:
15524A 6358 3/08	50, with policy/cert	Employer's Request For Group Insurance

complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SIGNATURE: Signature Not Verified Robert G. Lange Digitally signed by Robert G. Lange DN: cn=Robert G. Lange, c=US Date: 2008.04.28 13:24:52 -05'00'

TYPED NAME: Robert G. Lange
TITLE: Vice President, General Counsel and Assistant Secretary

DATE: 4/28/08

STATE OF ARKANSAS

REGULATION 19

INSURER: Ameritas Life Insurance Corp

This is to certify that the attached form(s) are in compliance with Rule and Regulation 19:

Form Number:	**Form Name:**
15524A 6358 3/08	Employer's Request for Group Insurance

SIGNATURE: Signature Not Verified Robert G. Lange Digitally signed by Robert G. Lange DN: cn=Robert G. Lange, c=US Date: 2008.04.28 13:23:59 -05'00'

TYPED NAME: Robert G. Lange

TITLE: Vice President, General Counsel and Assistant Secretary

DATE: 4/28/2008